



**Eye Priority, P.C.**  
Dr. Kelly de Simone, F.C.O.V.D.  
15725 South 46<sup>th</sup> Street ♦ Suite 112 ♦ Phoenix ♦ AZ ♦ 85048  
480-893-2300 ♦ Fax 480-893-0522

## ADULT VISION QUESTIONNAIRE

*Thank you for carefully completing the questionnaire. Please bring it to our office at your appointment time.*

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Sex: Male Female Marital Status: Single Married Divorced Widowed

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Numbers: Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Email \_\_\_\_\_ Preferred Method of Contact: Cell Home Work Email

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse Name \_\_\_\_\_ Occupation \_\_\_\_\_

Other family member's names and ages \_\_\_\_\_

### **Responsible Party and Insurance Information**

Person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Do you have Major Medical Insurance? Yes No

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Insured's SSN \_\_\_\_\_ Insured's Employer \_\_\_\_\_

I authorize the release of my medical and/or other information pertaining to my care at Eye Priority.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

### **Visual History**

What is the reason for today's visit? \_\_\_\_\_

When did these symptoms first begin? \_\_\_\_\_

Has the problem become better or worse? Please explain \_\_\_\_\_

Have you had a previous vision evaluation? Yes No

If yes, doctor's name: \_\_\_\_\_ Date of evaluation \_\_\_\_\_

Reason for examination: \_\_\_\_\_

Were glasses, contact lenses or other optical devices recommended? Yes No

If yes, what? \_\_\_\_\_

Are they used? Yes No If yes, when? \_\_\_\_\_

If no, why not? \_\_\_\_\_

Were any additional tests, treatments, or therapies recommended concerning your vision? Yes No

If yes, what? \_\_\_\_\_

Did you undergo these treatments? Yes No Explain: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

### **Visual Symptom Checklist**

- |  |  |
|--|--|
| <input type="checkbox"/> Headaches                                 | <input type="checkbox"/> Can respond better orally than in writing   |
| <input type="checkbox"/> Blurred vision at distance                | <input type="checkbox"/> Reverses letters or words                   |
| <input type="checkbox"/> Blurred vision at near                    | <input type="checkbox"/> Confuses right and left                     |
| <input type="checkbox"/> Double vision at distance                 | <input type="checkbox"/> Skips, rereads or omits words               |
| <input type="checkbox"/> Double vision at near                     | <input type="checkbox"/> Loss of place when reading                  |
| <input type="checkbox"/> Halos around lights                       | <input type="checkbox"/> Skips lines when reading                    |
| <input type="checkbox"/> Nausea associated with visual tasks       | <input type="checkbox"/> Vocalizes when reading silently             |
| <input type="checkbox"/> Need for very bright light for near tasks | <input type="checkbox"/> Reads slowly                                |
| <input type="checkbox"/> Need for very dim light for near tasks    | <input type="checkbox"/> Use of finger or object to keep place       |
| <input type="checkbox"/> Eyes hurt or burn                         | <input type="checkbox"/> Poor reading comprehension                  |
| <input type="checkbox"/> Eyes feel tired                           | <input type="checkbox"/> Comprehension decreases over time           |
| <input type="checkbox"/> Words appear to move or float on the page | <input type="checkbox"/> Tires easily/visual fatigue                 |
| <input type="checkbox"/> Motion sickness/car sickness              | <input type="checkbox"/> Difficulty switching focus from near to far |
| <input type="checkbox"/> Dizziness                                 | <input type="checkbox"/> Difficulty sustaining reading or near tasks |
| <input type="checkbox"/> Red or itchy eyes                         | <input type="checkbox"/> Falling asleep when reading                 |
| <input type="checkbox"/> Watery eyes                               | <input type="checkbox"/> Remembers better orally than by writing     |
| <input type="checkbox"/> Frequent eye rubbing                      | <input type="checkbox"/> Difficulty aligning columns of numbers      |
| <input type="checkbox"/> Frequent sties                            | <input type="checkbox"/> Poor time management                        |
| <input type="checkbox"/> Frequent blinking                         | <input type="checkbox"/> Short attention span/loses interest         |
| <input type="checkbox"/> Closing or covering one eye/squinting     | <input type="checkbox"/> Poor general motor coordination             |
| <input type="checkbox"/> Postural changes when doing desk work     | <input type="checkbox"/> Poor fine motor coordination                |
| <input type="checkbox"/> Head close to paper when reading/writing  | <input type="checkbox"/> Difficulty with scissors/small hand tools   |
| <input type="checkbox"/> Avoids reading or other near tasks        | <input type="checkbox"/> Inconsistent performance in work or sports  |
| <input type="checkbox"/> Tilts head when reading or near task      | <input type="checkbox"/> Difficulty with long-term memory            |
| <input type="checkbox"/> Moves head when reading                   | <input type="checkbox"/> Difficulty with short-term memory           |

Do you feel your vision hinders your daily activities in any way? Yes No

If yes, how? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Have you noticed any eye turn?**                      Yes      No      (If no, skip to Medical History)

When did you first notice or suspect eye turn? \_\_\_\_\_

Did the eye begin turning              Suddenly      Gradually (please circle one)

Does the eye turn      In      Out      Up      Down (circle all that apply)

Is the eye turn getting worse or better, or is there no change? \_\_\_\_\_

Is it always the same eye that turns?      Yes      No      Right      Left

Is the eye turn always present?              Yes      No  
If not, under what conditions is it present? (i.e. when tired, when ill, etc.) \_\_\_\_\_

Is the eye turn noticed more if you are looking:

Up Close                      Yes      No                                      To your right                      Yes      No

In distance                      Yes      No                                      Up                                      Yes      No

To your left                      Yes      No                                      Down                                      Yes      No

Has there been any treatment using an eye patch?              Yes      No

If yes, please describe when the patching was started, how patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results. \_\_\_\_\_

Does the eye turn less when the prescription is worn?                      Yes      No

Does one pupil ever appear to be larger than the other?                      Yes      No

Do you ever notice one or both eyes shaking rapidly?                      Yes      No

Have you ever been told that you have amblyopia (lazy eye)?                      Yes      No

Has there been any surgical treatment?                      Yes      No

If yes, describe the surgery, including the age surgery was performed, the number of operations, the eye operated on, an estimate of the cosmetic and subjective results. \_\_\_\_\_

Were you satisfied with the results of the surgery?                      Yes      No

Please explain \_\_\_\_\_

Was the surgeon satisfied with the results of surgery?                      Yes      No

Please explain \_\_\_\_\_

**Medical History**

**Do you or anyone in your immediate family (parents, grandparents, siblings, children) have any of the following:**  
(Please circle and **INCLUDE** who has/had condition)

- |  |   |
|--|---|
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Amblyopia                          |
| <input type="checkbox"/> Brain Tumor         | <input type="checkbox"/> Blindness                          |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Cataracts                          |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Glaucoma                           |
| <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Keratoconus                        |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Macular Degeneration               |
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Strabismus                         |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Turned or "lazy" eye               |
| <input type="checkbox"/> Surgeries           | <input type="checkbox"/> Vision related learning disability |
| <input type="checkbox"/> Thyroid Conditions  |   |

Date of most recent medical evaluation: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

For what problem / condition? \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

List all medications you are currently taking and for what condition: \_\_\_\_\_

List any vitamins and supplements you are currently taking: \_\_\_\_\_

Do you have a history of allergies? Yes No

If yes, please explain: \_\_\_\_\_

Current diet: Excellent Good Fair Poor

Do you smoke? Yes No Do you drink alcohol? Yes No How much? \_\_\_\_\_

Current state of health (explain): \_\_\_\_\_

### **Sports**

Are you seriously involved with athletics? Yes No

Do you feel you are achieving up to your potential in sports/athletics? Yes No

Of all the sports you have played, list the ones in which you:

Excel: \_\_\_\_\_

Avoid or do poorly: \_\_\_\_\_

### **Hobbies/Leisure Time**

Describe the types of activities that comprise the majority of your leisure time: \_\_\_\_\_

Do you watch TV? Yes No What is the size of the TV you watch? \_\_\_\_\_ Distance from TV? \_\_\_\_\_

If yes, how many hours per day? \_\_\_\_\_

How many days per week do you watch TV? \_\_\_\_\_

Do you play video games? Yes No If yes, which system? \_\_\_\_\_

How many days per week? \_\_\_\_\_ How many hours per day? \_\_\_\_\_

Do you play games on the computer or TV? \_\_\_\_\_ Distance from TV or computer? \_\_\_\_\_

Size of TV or Monitor? \_\_\_\_\_

Do you use a Smart Phone? Yes No If yes, how many hours per day? \_\_\_\_\_

**Computers**

When do you use a computer? (circle all that apply)      Work                      School                      Leisure activity

What types of computer work you perform? (circle all that apply)

- Word processing
- Programming
- Data entry
- E-mail

- Internet
- Games/Leisure activities
- Other (explain) \_\_\_\_\_

What type of computer do you use? (circle all that apply)      Laptop                      Desktop

Please indicate your monitor size \_\_\_\_\_

What is the distance from:

- Your eyes to the screen? \_\_\_\_\_
- Your eyes to the keyboard? \_\_\_\_\_
- Your eyes to your source documents? \_\_\_\_\_

Where is the top of the screen located? (circle one)

- Above eye level
- At eye level
- Below eye level

Where is the computer screen located when you are seated? (circle one)

- Directly in front of you
- To your right
- To your left

Where are your source documents located?

- Directly in front of you when seated
  - To your right
  - To your left
- Flat (horizontal)  
Vertical

Do you experience any of the following lighting problems in your work area?

- |   |     |    |
|---|-----|----|
| Glare from windows or other light sources | Yes | No |
| Reflections on your computer screen       | Yes | No |
| Difficulty reading source documents       | Yes | No |

Do you wear glasses, contact lenses, or other optical devices for computer work?

- |                  |       |    |
|------------------|-------|----|
| Glasses          | Yes   | No |
| Contact lenses   | Yes   | No |
| Other (explain): | _____ |    |

How many hours do you spend in front of a computer screen each day? \_\_\_\_\_

How do your eyes feel after working at the computer? \_\_\_\_\_

**Employment/School**

Current position: \_\_\_\_\_

Are you currently as student?    Yes    No    If yes, major course of study: \_\_\_\_\_

How many hours daily do you spend at a desk? \_\_\_\_\_

How many hours daily do you spend reading or studying? \_\_\_\_\_

How many hours daily do you spend working at near distances? \_\_\_\_\_

Do you feel you are achieving to your potential in work or school? Yes No

Do you feel you are getting adequate return for the amount of effort you put into a task? Yes No

If no, please explain: \_\_\_\_\_

Does your work or course of study demand comprehension of written documents or books? Yes No

Describe briefly your daily activities at work or in school: \_\_\_\_\_

Is there any other information you feel would be helpful/important as we treat you?

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**Form Completed by:** \_\_\_\_\_  
**Name** **Relationship to Patient**



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**RECORDS RELEASE/REQUEST**

TO: \_\_\_\_\_  
(Doctor/Hospital/School)

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

I hereby authorize the release of my copied medical records. I request that they be transferred to:

**Eye Priority**  
15725 South 46<sup>th</sup> Street, Suite 112  
Phoenix, AZ 85048  
Phone: (480) 893-2300  
Fax: (480) 893-0522

\_\_\_\_\_  
**Print Name of Patient**

From: \_\_\_\_\_ To: \_\_\_\_\_  
**Date of Records**

\_\_\_\_\_  
**Signature of Patient/Parent/Guardian** **Date**

*This authorization shall be considered valid for 12 months from date signed.*